Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
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Original Public Report

Report Issue Date: August 11, 2023

Inspection Number: 2023-1064-0003

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare St. Catharines, St Catherines

Lead Inspector	**Inspector Digital Signature**
Adiilah Heenaye (740741)	Adiilah H Heenaye Sumser Digitally signed by Adiilah H Heenaye Sumser Date: 2023.08.15 14:13:47 -04'00'

Additional Inspector(s)
Emily Robins (741074)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates:
June 7-8, 12-16, 21, 23, 26, 2023; and July 12-14, 17-19, 2023.

The following intakes were inspected in this Critical Incident (CI) inspection:

- Intake: #00003172 related to unexpected death of a resident.
- Intake: #00005564, Intake: #00005683 and Intake: #00021630 related to alleged abuse.
- Intake: #00087078 related to medication management.
- Intake: #00087808 related to falls.

The following intakes were completed in this CI inspection:

- Intake: #00017216 and Intake: #00089658 related to falls.

The following intakes were inspected in this complaint inspection:

- Intake: #00089775 related to housekeeping services, care provided to resident and falls.
- Intake: #00087474 related to medication management and plan of care.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1064-0002 related to O. Reg. 246/22, s. 40 inspected by Adiilah Heenaye (740741)

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Medication Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that there was a written plan of care for a resident that set out clear directions to registered staff specifically regarding administration of a drug.

Rationale and Summary

The home received a complaint of two medication incidents regarding administration of a drug.

A review of the resident's clinical records for 11 days from when the order was received for that drug confirmed the two medication incidents including eight other occasions where registered staff did not administer the drug as per the order.

Interview with registered staff indicated that the medication incidents occurred as the plan of care did not set clear directions to staff when to administer the drug to the resident.

An unclear plan of care for the resident resulted in medication errors.

Sources: Interview with registered staff; review of medication incident reports, critical incident reports, and the resident's clinical records. [740741]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

i. The licensee has failed to provide baths to a resident as per the plan of care.

Rationale and Summary

The plan of care for a resident indicated that the resident was to be showered at least once a week.

The resident's documentation related to bathing was reviewed for three months, which indicated that the resident missed their baths for two weeks in one month, for three weeks in the other month, and for one week in the third month.

Management confirmed that the resident did not receive their baths on the occasions described above.

Sources: Review of a resident's clinical records; interview with management. [740741]

ii. The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in the plan.

Rationale and Summary

An inspector noted that a resident bend over in their assistive device and attempted to grab an object off the ground in their room.

A registered staff indicated that the object on the floor in the resident’s room did not ensure a safe environment as was specified in the resident’s plan of care, and that this put the resident at risk for falls.

Failure to ensure that care was provided to a resident as specified in their plan of care placed them at risk for falls and potential injury from the fall.

Sources: Observation of a resident; interview with registered staff and a resident’s care plan. [741074]

iii. The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in the plan.

Rationale and Summary

It was noted that a resident’s bed was raised to the highest position when the resident was not in bed. A registered staff indicated that the resident’s plan of care did not specify to keep their bed in the highest position. Further, they indicated that it was not safe to do so because it increased the resident’s risk for falls.

Sources: Observation of a resident's bed; interview with staff; a resident's clinical records review. [741074]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of the care set out in the plan of care, specifically, ensuring that a resident's chair alarm is working, was documented.

Rationale and Summary

A resident's plan of care included staff to document whether the resident's chair alarm was in place and working. Staff were to complete this task by ensuring that the alarm sounded whenever the resident was transferred from their assistive device to the bed.

A resident was observed being transferred from their assistive device into the bed by staff where the chair alarm sounded.

Staff did not document that the chair alarm was in place and working after putting the resident to bed.

Failure to ensure that the provision of care set out in the plan of care, specifically, documenting that the resident's chair alarm was in place and working may have diminished the quality of communication amongst the heath care team and reduced staff accountability to provided care as specified in the plan.

Sources: Resident's clinical records; observation of a resident; interview with staff. [741074]

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to protect two residents from physical abuse.

Rationale and Summary

An incident of alleged physical abuse between two residents occurred where both residents sustained injuries. Both residents had a history of two other incidents of physical abuse between them on two other occasions prior to this incident.

The administrator confirmed that the home investigated this incident and that physical abuse occurred where the two residents sustained injuries after the incident despite the interventions already in place at that time.

There was actual harm caused to the residents.

Sources: Interviews with management and other staff; Review of the critical incident reports and the residents' clinical records. [740741]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The home has failed to ensure that their policy to promote zero tolerance of abuse and neglect of residents was complied with.

In accordance with FLTCA s. 25 (1), the licensee is required to ensure they have a policy in place to promote zero tolerance of abuse and neglect of residents, and must be complied with.

Specifically, staff did not comply with the policy "zero tolerance of abuse and neglect", #RC-02-02-02, dated January 2022.

Rationale and Summary

The home's policy on zero tolerance of abuse and neglect program, # RC-02-01-01, and policy titled zero tolerance of abuse and neglect: response and reporting, #RC-02-02-02, indicated that the home should ensure completion of full assessments including a pain assessment if there was contact, and a risk assessment of the resident involved when there was physical abuse.

Review of the clinical records and interview with the management staff indicated that a resident was not assessed after an incident of physical abuse occurred, nor a risk assessment was completed.

By failing to assess a resident after an incident of staff to resident physical abuse, resulted in risks for staff not identifying the needs of the resident and not having a documented plan to meet those needs.

Sources: Review of the abuse and neglect policies #RC-02-01-01, and # RC-02-01-02 and resident's clinical records; Interview with the Administrator and other staff. [740741]

WRITTEN NOTIFICATION: Training

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 10.

The licensee has failed to ensure that agency staff received training prior to performing their responsibilities related to all acts, regulations, policies of the ministry and similar documents, including policies of the licensee, that were relevant to their responsibilities.

Rationale and Summary

The home received a complaint from the resident's substitute decision maker (SDM) about two medication incidents. It was identified that agency registered staff did not administer a drug as per the directions of the prescriber.

Review of the training records related to the home's policies and specifically for medication incidents, indicated that agency staff were not trained on the home's policies.

Interview with the Administrator confirmed that the agency staff were not trained by the home specifically on the policies of the licensee.

By the home not training staff as per the policies of the licensee put residents at risk of their specific needs not being met.

Sources: Interview with the Administrator and staff; review of the home's orientation package for agency staff and list of training provided by the agency company. [740741]

WRITTEN NOTIFICATION: Plan of Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 12.

The licensee has failed to ensure that the plan of care for a resident was based on an oral health assessment.

Rationale and Summary

The MLTC received concerns that a resident did not receive a dental assessment when they had a change in their oral status.

A review of the resident's clinical records indicated that the resident did not receive an oral health assessment.

Management confirmed that the resident did not receive an oral health assessment when they had a change in their oral status.

Sources: Review of a resident's clinical records; Interview with the Administrator and Staff. [740741]

WRITTEN NOTIFICATION: Oral Care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 38 (1) (c)

The licensee has failed to ensure that a resident received oral care to maintain the integrity of the oral tissue that included an offer of dental services, subject to payment being authorized by the resident's substitute decision-maker (SDM), if payment was required.

Rationale and Summary

The MLTC received concerns that a resident did not receive dental care when they had a change in their oral status.

The resident's clinical records indicated a change in their oral status and that their SDM requested dental services for the resident.

The Administrator confirmed that the home did not arrange for dental services when the resident had a change in their oral health status and on the request of the SDM.

By the home failing to ensure that the resident was offered dental services when there was a change in their oral status, put the resident at risk for developing oral problems and not maintaining the integrity of the oral tissue.

Sources: Review of the resident's clinical records; Interview with staff. [740741]

WRITTEN NOTIFICATION: Falls prevention and management

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

The licensee has failed to comply with the following strategy to reduce or mitigate falls for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee is required to ensure that the Falls Prevention and Management Program which provides for strategies to reduce or mitigate falls, including the monitoring of residents, is complied with.

Specifically, staff did not comply with the policy “Falls Prevention and Management Program”, which was included in the licensee’s Falls Prevention and Management Program.

Rationale and Summary

The home’s policy “Falls Prevention and Management Program” indicated the following under Post-Fall Management Procedures: if a resident hits their head or is suspected of hitting their head (e.g., unwitnessed fall) the Clinical Monitoring Record is to be completed.

A resident’s documentation indicated that clinical monitoring of neuro-vitals was required and not completed as scheduled on six occasions when the resident fell.

Failure to monitor the resident’s neuro-vitals according to the home’s policy placed the resident at risk of undiagnosed injury from the fall and subsequent falls.

Sources: Falls Prevention and Management Program policy #RC-15-01-01 last revised March 2023, review of a resident’s clinical assessments and interview with staff. [741074]

WRITTEN NOTIFICATION: Medication management system

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)

The licensee has failed to comply with their policy titled Physician/ Nurse Practitioner Orders, #RC-16-01-04, last reviewed March 2023.

In accordance with O. Reg 246/22 s.11. (1) b, the licensee is required to ensure that written policies and protocols are developed for the medication management system to ensure the accurate administration of all drugs used in the home, and must be complied with.

Specifically, staff did not comply with the policy "Physician/ Nurse Practitioner Orders", # RC-16-01-04 and dated March 2023.

Rationale and Summary

The home's policy titled Physician/ Nurse Practitioner Orders, #RC-16-01-04, last reviewed March 2023, indicated that all physician/ nurse practitioner orders will be processed within 24 hours of being written.

The home received an order for a resident. Registered staff communicated the order to the pharmacy using the established process. However, the order was transcribed 5 days after.

By the home not processing the order completely within 24 hours of being written as per their policy, resulted in the resident not receiving their drugs as prescribed.

Sources: Interview with staff; review of the home's Physician/ Nurse Practitioner Orders policy, #RC-16-01-04, last reviewed March 2023, medication incident reports, critical incident reports and the resident's clinical records. [740741]

WRITTEN NOTIFICATION: Administration of drugs

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that a resident's drug was administered in accordance with the directions for use specified by the prescriber

Rationale and Summary

The home received a complaint from the resident's substitute decision maker (SDM) about two medication incidents that occurred on two specified dates.

A review of the resident's clinical records confirmed that the medication incidents occurred on the two specified dates and on another eight occasions.

Interview with the Administrator and registered staff confirmed that the drug was not administered to the resident in accordance with the directions for use specified by the prescriber.

The physician stated that the resident was placed at risk when the drug was not administered in accordance with the directions for use specified by the order.

Sources: Review of the critical incident reports, review of the home's investigative notes, the physician's order, the resident's clinical records and the medication incident reports; interview with the administrator, the physician, and staff. [740741]